Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Edward F. Wolski, MD/Wol+Med 2436 I-35 E. South, Suite #336 Denton, TX 76205	MFDR Tracking #: M4-06-4870-01 DWC Injured Er Date
Respondent Name and Box #: American Home Assurance Co. Rep. Box #: 19	Employe Insurance C

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENT

Requestor's Position Summary: "We have submitted to the carrier for reconsideration two charges for date of service, 4/4/05. First is the CPT Code 64999, nerve block. The carrier has denied this stating "This is an unlisted procedure. Please resubmit with a more descriptive code." And "Not documented". We believe this to be an incorrect denial as we submitted the documentation of the procedure as well as HIPPA Compliant EOB's from other carriers demonstrating that this is a valid code."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $263.00
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S PO6SITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Carrier paid the amount owed, $263.00, for DOS 040405, CPT Code 64999 on 04/12/06 via check number 34335547."

Principle Documentation:

1. Response to DWC 60

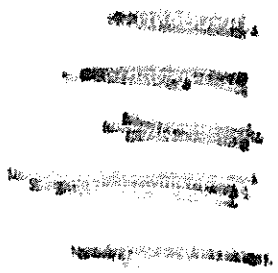
PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Reasons	Part V Reference	Amount Ordered
04/04/05	CPT Code 64999	N, F, 1	1, 2	$0.00
Total:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services on or after August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "N – Not Documented"; "F – Fee Guideline MAR Reduction"; and "1 – This is an unlisted procedure. Please resubmit with a more descriptive code."
2. The Requestor billed CPT Code 64999 which is defined in the 2005 CPT Code book as "Unlisted procedure, nervous system." Review of the submitted information reveals the Requestor did not submit SOAP notes or other pertinent information as to the treatment/service rendered to the claimant under this code. Therefore, per 28 Texas Administrative Code Section 133.307(g)(3)(B) reimbursement is not recommended.



PART VI: GENERAL PAYMENT POLICIES/REFERENCES

- Texas Labor Code Section. 413.011(a-d);
- Texas Labor Code Section. 413.031;
- Texas Labor Code Section. 413.0311;
- 28 Texas Administrative Code Section 133.307
- 28 Texas Administrative Code Section. 134.1; and
- Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Auditor III Medical Fee Dispute Resolution	July 30, 2008 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.